*** Notation: RYAN WHITE TITLE I PRESCRIPTION DRUGS FORMULARY COMMENTS**

A	*Medications available through the federal AIDS Drug Assistance Program* ***(ADAP)*** *via the Miami-Dade County Health Department. These drugs are available to clients fulfilling the ADAP eligibility requirements.*
B	*In order for a patient to obtain this medication through the Title I program, one of the two conditions (histoplasmosis or aspergillosis) must have been identified and documented in the client's chart by his/her physician. In addition, the* ***Ryan White Sporanox Letter of Medical Necessity*** *is required. Title I funds may only be used to cover one of the two conditions.*
C	*The* ***Ryan White Nutritional Supplements Letter of Medical Necessity*** *is required. Title I funds may only be used to reimburse for nutritional supplements for the treatment of indications experienced by HIV+ children 18 years and under (for Boost Liquid) and HIV+ children 1-10 years of age (for Resource Just for Kids). These nutritional supplements are only available in liquid form and require a referral from both a Physician and a Nutritionist.*
D	*These nutritional supplements are available in powder form only and require a referral from both a Physician and a Nutritionist.*
E	*Effective January 1, 1998, Title I funds may be used to reimburse for Protease Inhibitors and Non-Nucleoside Reverse Transcriptase Inhibitors (on a month-to-month basis) only when these medications are unavailable through ADAP.*
F	*Title I funds may only be used to reimburse for this medication for the treatment of Toxoplasmosis, and must be written as such on the prescription.*
G	*The* ***Ryan White Appetite Stimulant Letter of Medical Necessity*** *is required, and the need for this medication must be reassessed monthly. Title I funds may only be used to cover one (1) b.i.d. dosage, 2.5 m.g. of Dronabinol (Marinol).*
H	*To qualify for Title I coverage, the patient's testosterone level must be below a normal reading. Prescribing physicians must include the patient's most recent testosterone level on the prescription for this medication. If this information is not provided on the prescription, Title I will not cover the cost of this medication.*
I	*In order for a patient to obtain this medication through the Title I program, one of the following conditions must have been identified and documented in the client's chart by his/her physician:* *1. The patient is experiencing involuntary weight loss of 3% in 1 month, 5% in 6 months, or 10% in 12 months.* *or* *2. If the patient's baseline weight is not available, then the patient will qualify for Title I assistance if his/her Body Mass Index (BMI) is less than 80% of a normal reading.*
J	*To qualify for Title I coverage, the patient must experience a low serum testosterone level as defined by the current medical guidelines of the Florida Department of Health and Human Services (a testosterone level below normal as measured by the reference lab.) Prescribing physicians must include the patient's most recent testosterone level on the* ***Letter of Medical Necessity for Testosterone Gel (Androgel 1%)*** *. If this information is not provided, Title I will not cover the cost of this medication. In addition, the Ryan White Letter of Medical Necessity is required at the time of initial referral explaining the contraindication, and MUST be submitted with a dated lab report showing the testosterone level results.*
K	*Title I funds may only be used to reimburse for these medications for the treatment of insulin dependent diabetes mellitus secondary to HIV treatment, and must be written as such on the prescription.*
L	*Title I funds may only be used to reimburse for these medications for the treatment of indications experienced by HIV+ children 12 years and under. These medications are only available in liquid or suspension form.*
M	*In order for a patient to obtain this medication through the Title I program, one of the following conditions must have been identified and documented in the patient's chart by his/her physician: (1) patient has acute Herpes Zoster, and requires Valacyclovir 1000mg three (3) times daily; or, (2) patient requires Valacyclovir daily suppressive therapy for recurrent Herpes Simplex episodes occurring while receiving standard doses of daily suppressive Acyclovir therapy. To qualify for daily suppressive Valacyclovir therapy, the patient must have had* **more than one** *Herpes recurrence while receiving daily Acyclovir suppressive therapy. This must be documented by attaching a photocopy of a recent Acyclovir prescription to the Letter of Medical Necessity submitted with the* **first** *prescription for Valacyclovir tablets. This is not required on subsequent refills. Title I funds may* **only** *be used to pay for this medication if the patient is suffering from one of the two conditions specified above.*
N	*In order to receive Eprosartan (Teveten) through the Ryan White I program, the patient must have had a prior history of intolerability to the use of Angiotensin Converting Enzyme (ACE) Inhibitors.*
O	*The Ryan White Title I* ***Letter of Medical Necessity for Pantoprazole (Protonix)*** *must be signed by a Board certified gastroenterologist when this medication is indicated for the treatment of Erosive Esophagitis, or Barrett's Esophagus, or to treat a hypersecretory condition. In addition, the gastroenterologist must certify that a proton pump inhibitor is medically necessary.*

P	***The Letter of Medical Necessity for Olanzapine (Zyprexa)*** *is required, and must be completed as follows:* *1. The prescribing healthcare provider is required to complete Section I* ***only*** *for the initial prescription for Olanzapine (Zyprexa)* ***not*** *exceeding 20mg per day.* *2.The prescribing healthcare provider is required to complete Section II for every* ***new*** *prescription of Olanzapine (Zyprexa)* ***exceeding*** *20mg per day.* *In addition, as required by Ryan White Title I, Section II must include the following information:* ** Reason for Olanzapine (Zyprexa) dose >20mg /day* *** ***Previous*** *Olanzapine (Zyprexa) dosage* ** Duration of* ***previous*** *Olanzapine (Zyprexa) treatment*
Q	*Indication of Pantoprazole (Protonix) for the treatment of Helicobacter pylori is restricted to a non-refillable ten (10) day supply of twenty (20) tablets to be prescribed no more than twice in a one-year period, in conjunction with the appropriate antibiotics. The prescription must state that this drug is "medically necessary for treatment of Helicobacter Pylori."*
R	*Ofloxacin (Ocuflox) is restricted to ophthalmologist use only.*
S	*Physicians prescribing Neupogen to patients needing to access Title I pharmaceutical services are required to complete a Ryan White Title I Prior Authorization Form for Neupogen (Filgrastim). Prescribing physicians* **must** *submit the Ryan White Title I Prior Authorization Form to the Title I pharmacy along with the* **original** *prescription and* **lab** *results dated within the last three (3) months.*
T	*Physicians prescribing Procrit to patients needing to access Title I pharmaceutical services are required to complete a Ryan White Title I Prior Authorization Form for Procrit (Epoetin). Prescribing physicians* **must** *submit the Ryan White Title I Prior Authorization Form to the Title I pharmacy along with the* **original** *prescription and* **lab** *results dated within the last two (2) months.*
U	*There is no generic equivalent for this new brand name product.*
V	*Effective June 20, 2005, Quetiapine (Seroquel) is restricted to strengths no lower than 200mg. Therefore, only 200mg,300mg dosing strengths will be filled.*